He states he is 52 years old and a radio operator. He is 5' 10½" tall; weighs 152 pounds; his chest measurements are 34 to 39 inches; waist, 32½ inches; patela reflexs are exaggerated; pupil reflexes, normal; pulse 100; temperature 98; blood pressure 150 over 80; heart position normal, mitral systolic murmur transmitted to the anterior maxillary line; lungs normal; extremities normal. He has an impacted cerumen in both ears, has pyorrhea of all his teeth, a strong odor of tobacco on his breath, and I think I detected the odor of alcohol.

I have seen two of his checks. They are usually made on two different banks. They are made out to J. Larabee; they are signed "Howard E. Bliss." Across the face of the check is written "Compilation" with some number after it like 18 or 200. Then in the corner of the check it is marked "Wages." The checks are all numbered 172 irrespective of the bank they are on.

The publication of this data in the OFFICIAL JOURNAL might catch this fellow, or at least prevent other physicians from being buncoed. This man also pays the druggist with a check instead of using the money the doctor gives him in change.

Yours truly,

(Signed)————————

P.S. This man usually works on Sundays when the banks are closed.

MEDICAL JURISPRUDENCE†

HARTLEY F. PEART, ESQ.
San Francisco

Compensation for Professional Services

THE same general rules are ordinarily held applicable to the recovery by a physician for services rendered to a patient as in the case of a person rendering services of a non-medical nature. To establish his legal right to compensation the physician or surgeon must show that the patient or other person against whom recovery is sought, either expressly or impliedly agreed to pay for such services. In the normal course of the relationship between physician and patient it is seldom that any express contract for payment will be found, and the physician or surgeon must rely for his legal right to remuneration on the implied agreement which the law raises upon the rendition of services that the person benefited thereby will pay their reasonable value. Incidentally it should be noted that before any charge for medical attention will be allowed the physician must be duly licensed to practice medicine under applicable statutes and regulations.

Where a physician is called by one person to give medical care to another.—In this common situation the law has placed many difficulties in tho path of the physician or surgeon which may ultimately deprive him of his just fee if he relies for payment on the person calling him. The general rule is as follows: Plaintiff in an action to recover for services rendered a third person brought against the person at whose request they were rendered, must show an express contract to pay since the person sought to be charged has not himself received the care and attention. The implication of a promise to pay the reasonable value of professional services performed is not made in the case where a person requests a physician to render medical attention to another to whom the person making the request is under no legal obligation to furnish medical aid. Even though the recipient of the services may be closely related to the person making the request this will not of itself raise an implied agreement on the part of such person to pay the reasonable value of the services rendered. If, however, the person making the request is legally obligated to support the sick person as in the case of a minor child there is no question as to his liability for medical aid which may be necessary in the course of fulfilling that duty to support. In *McClenahan v. Keyes* (1922) 188 Cal. 574, a case decided some years ago but which still stands as a correct statement of the law today, the court held that a physician could not recover from a mother the value of services rendered her adult daughter in the absence of an express agreement to pay therefore. The same rule has been held to control the case of services rendered to a daughter-in-law. Of course the person who is directly benefitted by receiving the medical attention will be held liable regardless of these considerations.

The promise of a third person to pay for services which have already been rendered another or are in the process of being rendered.—An additional limitation is imposed upon such a promise by the Statute of Frauds providing that where one person guarantees or agrees to answer for the debt of another such agreement or promise must be in writing signed by the person promising before it will be held legally enforceable. The result of this rule is that in order to be certain of collecting his fee when rendering medical services, if the physician is relying on the financial ability of someone other than the person receiving the services, he should exact a written statement from the person from whom payment is expected that he will pay for the services so rendered to another.

The establishment of the amount of the fee to which the physician is entitled.—Assuming that the physician can establish a right to recover his fee against either the person who receives the medical attention or against the person who requests its rendition, the general rule in the absence of an express contract for a stipulated amount is that the physician is entitled to the *reasonable* value of his services. What is reasonable is a question of fact which must be determined upon proper evidence. Ordinarily the physician is entitled to recover the customary charge for similar services rendered by members of the medical profession in the community who occupy the same position as the complaining physician; and testimony of other physicians in the community is admissable to aid the court in arriving at the proper fee.

† Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from and syllabi of recent decisions and analyses of legal points and procedures of interest to the profession.

If legal action to recover a fee (where there is no express contract) is necessary, the law takes all relevant factors into account.—Of course the obvious factors such as the time devoted to the patient, the nature and complexity of his ailment, the number of visits which the physician makes, the type of operation which the surgeon performs, etc. will be considered by the court in determining what constitutes a reasonable fee in any particular case. In addition to these there are a number of considerations which may be accorded weight where the circumstances of the case in question warrant such treatment. For example it has been held in California and in other jurisdictions that where it is shown that there is a custom or usage among physicians in the community to graduate professional charges with reference to the financial condition and ability of the patient, such financial condition may be considered as affecting the reasonableness of the physician's charges. Other elements of varying importance are the professional standing of the physician, his learning, experience, and skill. In spite of what evidence with respect to the above factors may show, the unpaid physician is aided to some extent in collecting his bill by a presumption in which the court indulges primarily that the amount demanded is not unreasonable and that professional visits were not made unnecessarily.

Provision of Medical Officers For Military Services*

The questionnaires published in recent issues of The Journal elicited many thousands of replies. The requirements of military necessity do not permit stating the exact numbers of names which have been furnished to the Surgeon General at this time or the number who will be requested to come immediately into the service. Appreciation is tendered particularly to the secretaries of state medical societies and to the editors of state medical journals, who gave complete cooperation in circularization of the appeal to the medical profession.

Under Medical Preparedness in this issue of The Journal appears a statement from the Procurement and Assignment Service regarding the present status of needs of the armed services and other federal agencies, and regarding also actions recently taken by the Board of the Procurement and Assignment Service for Physicians, Dentists and Veterinarians in relation to some questions that have been raised. Every physician in the United States is likely to find before the war is over that special need for his services in some capacity has arisen. The number of physicians to be called into the armed services clearly is sufficiently great to dislocate much of the present status of medical practice. One needs only to point out that the expansion of the Army by another million men would require at least seven thousand additional physicians. An army of four million men would necessitate a total of about thirty-two thousand physicians taken from civilian practice. Moreover, the call is primarily for men under 36 years of age and at most under 45 years of age. On January 15 every medical reserve officer in a governmental department or agency and physically fit was notified that he would be considered available for active duty.

The whole purpose of the Procurement and Assignment Service for Physicians, Dentists and Veterinarians is to provide for the needs of the armed forces with the minimum amount of dislocation of medical service to civilian needs, including public health agencies, industrial plants and medical education. Another primary purpose is to place, as far as possible, men with special qualifications in duties for which they are particularly fitted. These purposes can be accomplished with the complete cooperation of the medical profession. Should the war be prolonged, however, from two to three years the majority of physicians under 45 years of age who are physically fit will be engaged in the military services. Those who are not physically fit to meet the standards of the Army and the Navy will unquestionably be called on for additional services beyond the practices in which they are now engaged. The needs of civilian defense, industry and public health must be met. The Procurement and Assignment Service plans to give to every physician who enrolls with that service for assignment a certificate and a numbered button to indicate that he has made himself available to the nation in this time of emergency. The medical profession can be depended on to do its utmost. Let us not fail!

* Note. This display editorial appeared on page 228 of the JOURNAL A. M. A., in its issue of January 17, 1942.

Provision of Medical Officers For Military Services*

At the time of the Pearl Harbor incident, Dec. 7, 1941, the Army was short approximately fifteen hundred physicians to bring all existing installations up to war strength. Requisition was made on the Procurement and Assignment Service immediately to secure such physicians under the age of 36. The number of physicians in the service was adequate to meet all professional demands in the care of patients but was not sufficient to provide physicians for all organizations on a war strength basis. Therefore the Procurement and Assignment Service on December 18 authorized the publication of application blanks for enrolment with a view to meeting the immediate needs of the Army. These blanks have been circulated by THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION and by many state organizations. Some confusion has arisen in that many physicians interpreted the enrolment blank as another call for every physican in the United States to register. Actually, only those ready to volunteer for immediate service were wanted and only the applications of those capable of meeting specified qualifications are being forwarded.

* This important notice appeared in the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION (issue of January 17, 1942, on page 231).

The continued registration of all MEN UNDER 36 WHO ARE IMMEDIATELY AVAILABLE for military duty in the Army or the Navy will suffice to meet the immediate needs of the military services, at least until completion of the roster system now being established in the office of the Procurement and Assignment Service.

Within sixty days the Procurement and Assignment Service expects to publish the physical requirements for service with every military, governmental, industrial and civil agency utilizing the services of physicians, dentists and veterinarians. Each physician, dentist or veterinarian will be asked to make a self analysis of his physical condition, so that he may himself determine with which of the agencies he is physically qualified to serve. Shortly thereafter the Procurement and Assignment Service expects to mail a new questionnaire and enrolment form. Each professionally qualified person will be asked to state, first, that he will volunteer his services in the interest of the national emergency; second, to state his first, second, third and fourth choice of the agencies which he will be willing to serve for the duration of the war. A list will be furnished of every military, governmental, industrial and civil agency requiring the services of physicians, dentists or veterinarians.

On self analysis of his physical condition, each man will be thus able to determine whether his physical fitness qualifies him for duty with the requisitioning agencies. On receipt of the enrolment form the Procurement and Assignment Service will issue a certificate of enrolment and a numbered button which will certify that the recipient has offered his services in the interests of the national defense. Thus, those who remain at home in an essential capacity will derive the satisfaction of knowing that they have offered their utmost to the national emergency and that this offer has been formally recognized by the Procurement and Assignment Service.

SAM F. SEELEY, Executive Officer.
MORRIS FISHBEIN, Chairman Committee on Information.
Procurement and Assignment Service.

COMMUNICABLE DISEASES ARE BIGGEST DEFENSE PROBLEM

"Communicable diseases, including those which are primarily pediatric [pertaining to diseases of children] conditions, are a far greater problem of defense and war than are injuries incurred in battle," Wilburt C. Davison, M.D., Durham, N. C., declares in the November issue of *War Medicine,* in an article suggesting a program for combating such conditions. *War Medicine* is a bimonthly publication published by the American Medical Association, Chicago, in cooperation with the Division of Medical Sciences of the National Research Council, Washington, D.C.

"Perhaps in the present emergency a consulting pediatrician who has had experience in preventing communicable diseases among children should be appointed [to the Army]," Dr. Davison says. "In the light of the figures on the frequency of children's diseases in the Army and Navy during the last war, this suggestion is not as foolish as it may seem."

Communicable diseases in both the Army and the Navy of the United States during World War I, he points out, were responsible for more hospital admissions, deaths and days lost than were injuries of battle. One in every 3 soldiers and sailors had one or more of these diseases, and 1 in every 133 in the military and naval services died of infectious disease.

"Although the influenza, pneumonia, bronchitis and tonsillitis of the epidemic of 1918 were responsible for most of the morbidity [illness] and mortality," Dr. Davison says, "half a million soldiers and sailors were affected by the purely pediatric diseases, especially mumps, measles, scabies, rheumatic fever, vaccinia [cowpox], rubella (German measles) scarlet fever, diphtheria, meningitis, dysentry, impetigo and chickenpox, in that order. These twelve children's diseases affected twice as many men in the Army and Navy as did wounds and half as many as did influenza. To reduce this incidence of infectious diseases in troops, pediatricians would recommend the adoption of the preventive measure which have been found to be efficacious for children. Some of these precautions at present are being used in the Army and Navy, but more of them should be applied. . . ."

Dr. Davison makes the following specific recommendations: as soon as a recruit is inducted in the service he should have tests for diphtheria, scarlet fever, tuberculosis and syphilis, be vaccinated against smallpox and be inoculated with typhoid-paratyphoid vaccine and tetanus toxoid or a combined tetanus-diphtheria toxoid. A skin test for sensitivity, of course, should be done first. Alternate recruits should receive influenza vaccine in order that data on its immunizing value may be collected.

"These cutaneous [skin] tests and inoculations," he says, "can be done by the physicians at the induction board's headquarters, and the results can be ready forty-eight to seventy-two hours later by the camp physician and recorded on the recruits' service records."

He also advises that the efficacy of the immunization against diphtheria should be tested three months after the inoculations and that the scarlet fever tests should be repeated annually. If these tests become positive inoculations should be repeated. Regarding tests for tuberculosis, he says that x-ray films of the chest without tuberculin tests are not nearly as accurate in the diagnosis of the disease and he advises that both be used.

Regarding the service records, Dr. Davison advises that the dates of inoculations, the results of the tests and an accurate statement that the recruit has or has not had measles, German measles, chickenpox, mumps, whooping cough, scarlet fever and rheumatic fever be entered thereon. As to the reliability of information on

these diseases obtained from the recruit, he says that the facts can easily be verified by the local draft board from the recruit's parents and family physician during the interval between his placement in class 1-A and his induction. He goes on and savs that if there is any doubt about the history, the recruit should be assumed to be susceptible.

"These service records," the author suggests, "should be summarized in advance and lists made of the recruits who are susceptible to each disease, especially mumps and measles, as they affected 353,328 soldiers and sailors in the last war. Usually the percentage of soldiers who have had contagious diseases is low for youths from the country and high for those from cities, because of greater exposure of the latter. However, the crowded school buses of the consolidated country schools may make up for the crowded city streets. . . ."

Regarding objections that may be raised that such elaborate precautions will delay the training program of the recruits, Dr. Davison savs among other things that "Surely the 2,482 deaths from measles among the soldiers and sailors in the last war would justify the trial of preventive measures in spite of the time they might consume or the difficulties involved. This plan is not impractical, and the need for speed and other military factors during mobilization should not prevent its utilization for large as well as for small commands. The measures suggested, in addition to reducing the deaths from children's diseases, actually would save time. With the methods used in the last war, which have not been materially changed, 9,374,334 davs were lost through children's diseases, quarantine and carrier pogroms (two davs per man). Knowing which troops have had and are immune to these diseases will eliminate many erroneous diagnoses and prevent far more loss of time because of unnecessary quarantine than will be taken up by the program outlined. If the 'days lost' are rduced by only 10 per cent, the result will compensate for these precautions. If the yare put into effect, the reduction will be much more than 10 per cent, though even pediatricians are not optimistic enough to expect to eliminate all communicable diseases. . . .

"As an example of the operation of the plan suggested, if measles breaks out a pediatrically trained medical officer will follow the procedure used in most children's hospitals, namely to round up up all possible exposed persons whose records indicate that they have not had measles and to give them convalescent serum, serum and desensitizing if necessary. This is in contrast to the quarantining of thirty-seven of the two hundred and eighteen barracks which was recently done in one of the camps. . . ."

MEDICAL EPONYM

Hunter's Glossitis

The strongly individualistic contributions of Dr. William Hunter (1861-), pathologist to the Charing-Cross Hospital, to knowledge of the nature and causes of pernicious anemia include numerous descriptions of the glossitis that is often identified by his name. The following quotation is from his article, "Further Observations on Pernicious Anaemia (Severe Cases): A chronic infective disease: Its relation to infection from the mouth and stomach: Suggested serum treatment," which appeared in the *Lancet* (1:221-224, 296-299, 371-377, 1900):

> . . . I was struck by the curious character of the sores on the tongue—localised inflamed patches sometimes showing vesicles filled with clear serum situated under the tip of the tongue, the inflamed areas shifting from time to time, with atrophic appearance of the intervening mucosa. The condition thus described is not one of ordinary stomatitis or glossitis such as one meets with as the result of the local irritation of decayed or irregular teeth. . . . Another feature I have had to note is what I may term the "periodicity" of the stomatitis—its variability from time to time, independently apparently of treatment, notably its greater severity at the outset of the disease, usually tending to subside or at least to give less discomfort as the disease advances.—R. W. B., in *New England Journal of Medicine.*

MEDICAL EPONYM

Landry's Paralysis

Dr. Jean Baptiste Octave Landry (1826-1865) published "Note sur la paralysie ascendante aigue [Note on Acute Ascending Paralysis]" in the *Gazette hebdomadaire de médecine et de chirurgie* (Paris) 6:472-474 and 486-488, 1859). A portion of the translation follows:

> The object of this note is to call attention to a morbid condition that is rather uncommon and generally unknown but deserves a place among the most remarkable diseases in the pathological category.
>
> In these cases, the symptoms, beginning in the extremities, successively involve the upper portions of the body, those more central relatively to the nervous system becoming gradually augmented in intensity in the invaded organs. These symptoms frequently tend to become general, and then produce a definite *general paralysis* with all the characteristics of that of the insane. . . .
>
> I simply add that, nearly always slowly progressive, it occasionally runs a very rapid course, and may become serious or even fatal in a very short time. It is this variety that I propose to designate *ascending* or *acute centripetal paralysis.*—R. W. B., in *New England Journal of Medicine.*

MEDICAL EPONYM

Bundle of His

The original description of this structure, by Wilhelm His, Jr. (b. 1863), is found in the article "Die Thätigkeit des embryonalen Herzens und deren Bedeutung für die Lehre von der Herzbewegung beim Erwachsenen [The Activity of the Embryonal Heart and Its Significance in the Theory of the Contraction of the Adult Heart]," which appeared in *Arbeiten aus der medizinische Klinik zu Leipzig* (14-49, 1893). A portion of the translation follows:

> After prolonged investigation, I have succeeded in finding a muscular bundle that connects the auricular and the ventricular septums. This has hitherto escaped observation because, on account of its small dimensions, it is visible in its entire extent only if this area is cut lengthwise. Up to the present time, I have been able to trace the course of the bundle in such sections and also in serial sections in a grown mouse, a newborn dog, two newborn infants and one adult (thirty years) human being. The bundle arises from the posterior wall of the right auricle near the auricular septum in the atrioventricular groove, continues along the upper margin of the ventricular septum with frequent interlacing of the muscle fibers of the two structures, and then runs forward until, near the aorta, it forks, dividing into a right and left branch. . . .—R. W. B., in *New England Journal of Medicine.*